House File 2356

H-8075

Amend House File 2356 as follows:

1. Page 5, after line 33 by inserting:

<Sec. ___. TERMINATION OF MEDICAID MANAGED CARE CONTRACTS RELATIVE TO LONG-TERM SERVICES AND SUPPORTS POPULATION —— TRANSITION TO FEE-FOR-SERVICE. The department of human services shall, upon the effective date of this Act, provide written notice in accordance with the termination provisions of the contract, to each managed care organization with whom the department executed a contract to administer the Iowa high quality health care initiative as established by the department, to terminate such contracts as applicable to the Medicaid long-term services and supports population, following a sixty-day transition period. The department shall transfer the long-term services and supports population to fee-for-service program administration. The transition shall be based on a transition plan developed by the department and submitted to the council on human services and the medical assistance advisory council for review.

Sec. ___. INTEGRATED HEALTH HOME FOR PERSONS WITH SERIOUS AND PERSISTENT MENTAL ILLNESS (SPMI INTEGRATED HEALTH HOME). The department of human services shall adopt rules pursuant to chapter 17A and shall amend existing Medicaid managed care contracts to carve out SPMI integrated health homes services as specified in the Medicaid state plan amendment, IA-16-013, from Medicaid managed care contracts and instead provide SPMI integrated health home services through the fee-for-service payment and delivery system.

Sec. ___. RECALCULATION OF CERTAIN CAPITATION RATES UNDER MEDICAID MANAGED CARE. For the fiscal year beginning July 1, 2018, the department of human services shall utilize Medicaid program claims paid data for the period beginning April 1, 2015, and ending March 31, 2016, as base data to develop and certify capitation rates for providers of home and community-based intellectual disability waiver services under Medicaid managed care.

Sec. ___. MEDICAID MANAGED CARE OVERSIGHT. The department of human services shall amend the Medicaid managed care contracts and adopt rules pursuant to chapter 17A to provide that beginning July 1, 2018, all of the following shall apply:

1. MEMBER STATUS CHANGES.

a. A Medicaid managed care organization shall provide prior notice, in writing, to a member and to any affected provider, of any change in the status of the member at least thirty days prior to the effective date of the change in status. If notification is not received by the provider and the member continues to receive services from the provider, the Medicaid managed care organization shall reimburse the provider for services rendered.

b. If a member transfers from one managed care organization to another, the managed care organization from which the member is transferring shall forward the member's records to the managed care organization assuming the member's coverage at least thirty days prior to the managed care organization assuming such coverage.

c. If a provider provides services to a member for which the member is eligible while awaiting any necessary authorization, and the authorization is subsequently approved, the provider shall be reimbursed at the contracted rate for any services provided prior to receipt of the authorization.

2. DATA. Managed care organizations shall report to the department of human services not only the percentage of medical and pharmacy clean claims paid or denied within a certain time frame, but shall also report all of the following on a quarterly basis:

a. The total number of original medical and pharmacy claims submitted to the managed care organization.

b. The total number of original medical and pharmacy claims deemed rejected and the reason for rejection.

c. The total number of original medical and pharmacy claims deemed suspended, the reason for suspension, and the number of

days from suspension to submission for processing.

d. The total number of original medical and pharmacy claims initially deemed either rejected or suspended that are subsequently deemed clean claims and paid, and the average number of days from initial submission to payment of the clean claim.

e. The total number of medical and pharmacy claims that are outstanding for thirty, sixty, ninety, one hundred eighty, or more than one hundred eighty days, and the total amount attributable to these outstanding claims if paid as submitted.

f. The total amount requested as payment for all original medical or pharmacy claims versus the total amount actually paid as clean claims and the total amount of payment denied.

g. The total number of original medical and pharmacy claims received, the number of such claims for which one hundred percent of the requested amount was paid, the number of such claims for which less than one hundred percent of the requested amount was paid and the percentage actually paid, and the total dollar amount of payments denied.

3. REIMBURSEMENT. For the fiscal year beginning July 1, 2018, Medicaid providers or services shall be reimbursed as follows:

a. For fee-for-service claims, reimbursement shall be calculated based on the methodology in effect on June 30, 2018, for the respective provider or service.

b. For claims subject to a managed care contract:

(1) Reimbursement shall be based on the methodology established by the managed care contract. However, any reimbursement established under such contract shall not be lower than the rate floor established by the department of human services as the managed care organization provider or service reimbursement rate floor for the respective provider or service in effect on June 30, 2018.

(2) For any provider or service to which a reimbursement increase is applicable for the fiscal year under state law,

upon the effective date of the reimbursement increase, the department of human services shall modify the rate floor in effect on June 30, 2018, to reflect the increase specified. Any reimbursement established under the managed care contract shall not be lower than the rate floor as modified by the department of human services to reflect the provider rate increase specified.

(3) Any reimbursement established between the managed care organization and the provider shall be in effect for at least twelve months from the date established, unless the reimbursement is increased. A reimbursement rate that is negotiated and established above the rate floor shall not be decreased from that amount for at least twelve months from the date established.

4. PRIOR AUTHORIZATION.

a. Any change by a Medicaid managed care organization in a requirement for prior authorization for a prescription drug or service shall be preceded by the provision of sixty days' prior written notice published on the managed care organization's internet site and provided in writing to all affected members and providers before the effective date of the change.

b. Each managed care organization shall post to the managed care organization's internet site prior authorization data including but not limited to statistics on approvals and denials of prior authorization requests by physician specialty, medication, test, procedure, or service, the indication offered, and if denied, the reason for denial.

Sec. ___. MEDICAID STATE PLAN OR WAIVER AMENDMENTS. The department of human services shall seek any Medicaid state plan or waiver amendments necessary to administer this Act.

Sec. ___. EFFECTIVE DATE. The following, being deemed of immediate importance, take effect upon enactment.

1. The section of this Act related to termination of Medicaid managed care contracts relative to long-term services and supports populations.

2. The section of this Act related to SPMI integrated health home services.

3. The section of this Act related to the recalculation of certain capitation rates under Medicaid managed care.

4. The section of this Act related to Medicaid managed care oversight.

5. The section of this Act related to Medicaid state plan or waiver amendments.>

2. Title page, by striking lines 1 through 4 and inserting <An Act relating to the provision of certain health care services, including through agreements between individuals and health care professionals for the provision of certain primary care health services, and including through the Medicaid program, and including effective date provisions.>

3. By renumbering as necessary.

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HEDDENS of Story

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ANDERSON of Polk